STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING _____ B. WING _____	C 01/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE HOME HEALTH	**14649 HIGHWAY 41 NORTH, SUITE 200 EVANSVILLE, IN 47725**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This was a Federal home health complaint investigation survey. Complaint #: IN00141801; Substantiated, federal deficiencies related to the allegation are cited. Unrelated deficiencies are also cited. Survey Date: 1-3-14 Medicaid Vendor #: 100265610A Surveyor: Vicki Harmon, RN, PHNS Agency census: 198 skilled 0 home health aide only 0 personal services Quality Review: Joyce Elder, MSN, BSN, RN January 9, 2014	G 000		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure visits, procedures, and treatments had been provided in accordance with physician orders in 4 (#s 1, 2, 3, and 4) of 4 records reviewed creating the potential to affect all of the agency's 198 current patients.	G 158		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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The findings include:

1. Clinical record number 1 included a plan of care established by the physician for the certification period 0-17-13 to 12-16-13 that states, "SN [skilled nurse] 1w x 8 [1 time per week for 8 weeks] . . . to . . . assess med [medication] regimen knowledge including dosage, se [side effects], name, route, frequency, desired action, adverse reactions, compliance/set up."

A. The plan of care identified the patient received 13 different oral medications daily. The Director of Nursing, employee A, indicated, on 1-3-14 at 10:05 AM, the plan of care did indicate the nurse was to fill the patient's medication planner with these 13 different medications on a weekly basis.

B. A skilled nurse visit note dated 12-10-13 failed to evidence the registered nurse, employee B, had filled the patient's medication planner as ordered. The record failed to evidence any other SN visits had been provided the week of 12-7-13 to fill the medication planner.

2. Clinical record number 2 included a plan of care established by the physician for the certification period 7-20-13 to 9-17-13. The record evidenced the patient had been discharged from services on 9-17-13. The plan of care states, "SN 1 week 2; 2 week 2; 1 week 6 . . . Assess postural vital signs [a series of vital signs taken while the patient is lying down, sitting and then standing to assess changes in blood pressure and pulse rates] . . . skilled assessment with focus on CHF [congestive heart failure] . . .

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weight."

A. Skilled nurse visit notes, dated 7-25-13,7-30-13, 8-2-13, 8-3-13, 8-4-13, 8-6-13, 8-7-13, 8-9-13, 8-10-13, 8-11-13, 8-13-13, and 8-14-13, evidenced the nurse had taken the vital signs while the patient was sitting but failed to evidence the nurse had taken the vital signs while the patient was lying down or standing.

B. The record failed to evidence the skilled nurse had assessed the patient's weight the weeks of 7-21-13 or 7-28-13.

C. The Director of Nursing, employee A, indicated, on 1-3-14 at 11:30 AM, the SN visit notes did not evidence the nurse had completed postural vital signs and that the nurse had not assessed the patient's weight at least weekly as would be the agency's usual practice for CHF patients.

D. The record identified the patient had wounds on the both lower legs. The record included a dressing change order dated 8-9-13 that states, "Left lower leg - Apply petroleum gauze over dorsal foot. Place alginate strip between toes and over toes. Alginate square over dorsal foot. Cover wound area with ABDs, bulky gauze, and double layer tubigrip E over toes and dorsal foot."

1.) A SN visit note dated 8-10-13 failed to evidence the SN had applied the Alginate between the toes and over the dorsal foot as ordered.

2.) The Director of Nursing, employee A, indicated, on 1-3-14 at 11:30 AM, the SN had not

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completed the dressing change on 8-10-13 as ordered.

3. Clinical record number 3 included a plan of care established by the physician for the certification period 10-22-13 to 12-20-13. The record evidenced the patient had been discharged from services on 12-20-13. The plan of care states, "SN 2 week 1; 1 week 8 SN to assess . . . med regimen . . . compliance/set up . . . Assess postural vital signs."

A. The plan of care identified the patient received 19 different oral medications on a daily basis. SN visit notes, dated 10-30-13, 11-7-13, 11-21-13, 11-27-13, and 12-5-13, failed to evidence the SN had completed the medication set-up as ordered.

B. SN visit notes, dated 120-30-13, 11-7-13, 11-13-13, 11-21-13, 11-27-13, 12-5-13, and 12-13-13, evidenced the nurse had taken the vital signs while the patient was sitting but failed to evidence the nurse had taken the vital signs while the patient was lying down or standing.

C. A SN visit note dated 11-13-13 evidenced the SN had set-up the patient's medications but failed to evidence the patient and/or caregiver was present as required by the agency's own policy.

4. Clinical record number 4 included a verbal start of care order dated 12-10-13 that states, "SN 1 day 1 to evaluate for home care . . . assess med regimen . . . compliance/set up."

A. The record included a start of care comprehensive assessment dated 12-10-13 that

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G 158	Continued From page 4 identified the SN had checked the patient's medication planner box to ensure the medications had been properly set up. The note failed to evidence the patient and/or caregiver were present as required by the agency's own policy. B. The record included a resumption of care comprehensive assessment dated 12-24-13. The record failed to include an order to resume the home care services. C. The record included a SN visit note dated 1-2-14. The record failed to evidence an order for the SN visit. D. The Director of Nursing, employee A, indicated, on 1-3-14 at 11:40 AM, the record did not include a resumption of care order or an order for the 1-2-14 SN visit. The Director indicated the agency's computer system had been down and paper orders had not been completed. 5. The agency's 2009 "Client Plan of Care" policy number 3011 states, "Vibrant! services are furnished to clients . . . following a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, podiatry, chiropractic, ophthalmology [sic] or dentistry." 6. The agency's 2009 "Safe/Effective Use of Medications" policy number 3029 states, "Nurses will only pre-fill medi-planners in the presence of patients/caregivers and will document their presence during this procedures."	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with	G 159		

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the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.

This STANDARD is not met as evidenced by:
Based on clinical record and agency policy review and interview, the agency failed to ensure plans of care had been developed in 2 (#s 1 & 4) of 4 records reviewed creating the potential to affect all of the agency's 198 current patients.

The findings include:

1. Clinical record number 1 included a plan of care established by the physician for the certification period 10-17-13 to 12-15-13 and included a verbal order to continue the skilled nurse services for the certification period 12-16-13 to 02-13-14. The record failed to evidence a plan of care that included all of the required items had been established for the certification period 12-16-13 to 02-13-14.

2. Clinical record number 4 included a verbal start of care order dated 12-10-13 that identified skilled nursing and physical therapy services were to be provided during the certification period 12-10-13 to 02-07-14. The record failed to evidence a plan of care that included all of the required items had been established for the certification period 12-10-13 to 02-17-14.

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G 159	Continued From page 6 3. The Director of Nursing, employee A, indicated, on 1-3-14 at 9 AM, the agency's computer server had "crashed" and that plans of care had not been generated as a result for some patients. 4. The agency's 2009 "Care Planning Process" policy number 3026 states, "A written plan of care will be developed after admission and updated at least every sixty days (60) or as client's condition dictates . . . Plan of Care: The clinical plan of care, including pertinent diagnoses, mental status, types of services/equipment, frequency of visits, goals and interventions appropriate to each discipline, prognosis, rehabilitation potential, functional limitations, precautions, activities, nutritional requirements, medications, treatments, safety measures, instructions." 5. The agency's 2009 "Client Plan of Care" policy number 3011 states, "The client plan of care is developed by the RN or therapist in consultation with the physician and interdisciplinary team members, is documented on the home health certification and plan of care form (CMS 485)."	G 159		
G 163	484.18(b) PERIODIC REVIEW OF PLAN OF CARE The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the same 60 day episode or more frequently when there is a beneficiary elected transfer; a	G 163		

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significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the 60 day episode.

This STANDARD is not met as evidenced by:
Based on clinical record and agency policy review and interview, the agency failed to ensure plans of care had been reviewed at least every sixty (60) days in 1 (# 1) of 1 record reviewed of patients on service for greater than 60 days creating the potential to affect all of the agency's patients that receive services longer than 60 days.

The findings include:

1. Clinical record number 1 evidenced a start of care date of 6-9-13. The record included a plan of care established by the physician for the certification period 10-17-13 to 12-15-13 and included a verbal order to continue the skilled nurse services for the certification period 12-16-13 to 02-13-14. The record failed to evidence the plan of care had been reviewed by the physician for the certification period 12-16-13 to 02-13-14.

2. The Director of Nursing, employee A, indicated, on 1-3-14 at 9 AM, the agency's computer server had "crashed" and plans of care had not been generated as a result for some patients.

3. The agency's 2009 "Client Plan of Care" policy number 3011 states, "The client plan of care: . . . is reviewed by the attending physician in consultation with the RN or therapist and interdisciplinary team members at such intervals

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G 163	Continued From page 8 as the severity of the client illness requires, but at least once every two (2) months."	G 163		
G 170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure skilled nusring services had been provided in accordance with physician orders in 4 (#s 1, 2, 3, and 4) of 4 records reviewed creating the potential to affect all of the agency's 198 current patients. The findings include: 1. Clinical record number 1 included a plan of care established by the physician for the certification period 0-17-13 to 12-16-13 that states, "SN [skilled nurse] 1w x 8 [1 time per week for 8 weeks] . . . to . . . assess med [medication] regimen knowledge including dosage, se [side effects], name, route, frequency, desired action, adverse reactions, compliance/set up." A. The plan of care identified the patient received 13 different oral medications daily. The Director of Nursing, employee A, indicated, on 1-3-14 at 10:05 AM, the plan of care did indicate the nurse was to fill the patient's medication planner with these 13 different medications on a weekly basis. B. A skilled nurse visit note dated 12-10-13	G 170		

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failed to evidence the registered nurse, employee B, had filled the patient's medication planner as ordered. The record failed to evidence any other SN visits had been provided the week of 12-7-13 to fill the medication planner.

2. Clinical record number 2 included a plan of care established by the physician for the certification period 7-20-13 to 9-17-13. The record evidenced the patient had been discharged from services on 9-17-13. The plan of care states, "SN 1 week 2; 2 week 2; 1 week 6 . . . Assess postural vital signs [a series of vital signs taken while the patient is lying down, sitting and then standing to assess changes in blood pressure and pulse rates] . . . skilled assessment with focus on CHF [congestive heart failure] . . . weight."

A. Skilled nurse visit notes, dated 7-25-13,7-30-13, 8-2-13, 8-3-13, 8-4-13, 8-6-13, 8-7-13, 8-9-13, 8-10-13, 8-11-13, 8-13-13, and 8-14-13, evidenced the nurse had taken the vital signs while the patient was sitting but failed to evidence the nurse had taken the vital signs while the patient was lying down or standing.

B. The record failed to evidence the skilled nurse had assessed the patient's weight the weeks of 7-21-13 or 7-28-13.

C. The Director of Nursing, employee A, indicated, on 1-3-14 at 11:30 AM, the SN visit notes did not evidence the nurse had completed postural vital signs and that the nurse had not assessed the patient's weight at least weekly as would be the agency's usual practice for CHF patients.

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D. The record identified the patient had wounds on the both lower legs. The record included a dressing change order dated 8-9-13 that states, "Left lower leg - Apply petroleum gauze over dorsal foot. Place alginate strip between toes and over toes. Alginate square over dorsal foot. Cover wound area with ABDs, bulky gauze, and double layer tubigrip E over toes and dorsal foot."

1.) A SN visit note dated 8-10-13 failed to evidence the SN had applied the Alginate between the toes and over the dorsal foot as ordered.

2.) The Director of Nursing, employee A, indicated, on 1-3-14 at 11:30 AM, the SN had not completed the dressing change on 8-10-13 as ordered.

3. Clinical record number 3 included a plan of care established by the physician for the certification period 10-22-13 to 12-20-13. The record evidenced the patient had been discharged from services on 12-20-13. The plan of care states, "SN 2 week 1; 1 week 8 SN to assess . . . med regimen . . . compliance/set up . . . Assess postural vital signs."

A. The plan of care identified the patient received 19 different oral medications on a daily basis. SN visit notes, dated 10-30-13, 11-7-13, 11-21-13, 11-27-13, and 12-5-13, failed to evidence the SN had completed the medication set-up as ordered.

B. SN visit notes, dated 120-30-13, 11-7-13, 11-13-13, 11-21-13, 11-27-13, 12-5-13, and 12-13-13, evidenced the nurse had taken the vital

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signs while the patient was sitting but failed to evidence the nurse had taken the vital signs while the patient was lying down or standing.

C. A SN visit note dated 11-13-13 evidenced the SN had set-up the patient's medications but failed to evidence the patient and/or caregiver was present as required by the agency's own policy.

4. Clinical record number 4 included a verbal start of care order dated 12-10-13 that states, "SN 1 day 1 to evaluate for home care . . . assess med regimen . . . compliance/set up."

A. The record included a start of care comprehensive assessment dated 12-10-13 that identified the SN had checked the patient's medication planner box to ensure the medications had been properly set up. The note failed to evidence the patient and/or caregiver were present as required by the agency's own policy.

B. The record included a resumption of care comprehensive assessment dated 12-24-13. The record failed to include an order to resume the home care services.

C. The record included a SN visit note dated 1-2-14. The record failed to evidence an order for the SN visit.

D. The Director of Nursing, employee A, indicated, on 1-3-14 at 11:40 AM, the record did not include a resumption of care order or an order for the 1-2-14 SN visit. The Director indicated the agency's computer system had been down and paper orders had not been completed.

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G 170	Continued From page 12 5. The agency's 2009 "Client Plan of Care" policy number 3011 states, "Vibrant! services are furnished to clients . . . following a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, podiatry, chiropractic, ophthalmology [sic] or dentistry." 6. The agency's 2009 "Safe/Effective Use of Medications" policy number 3029 states, "Nurses will only pre-fill medi-planners in the presence of patients/caregivers and will document their presence during this procedures."	G 170		